Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CARLOS JOSE GARCIA
2435 W OAK ST STE 103
DENTON TX 76201-4313

Respondent Name
CITY OF DENTON

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-05-3711-02

MFDR Date Received
January 24, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The specific services requested and authorized were (1) 62290 (discography); (2) 64999 (unlisted procedure code, which covers IDET or intradiscal electrothermal therapy); (3) 99141 (intravenous sedation supervised by a physician). . . . The unlisted procedure code 64999 was paid at an alarmingly low rate. There is no basis for such a low reimbursement which averages three times this amount in 99% of the workman's compensation carriers in the state of Texas. . . . The code used for denial of payment 99070 according to TWCC states 'the value of this service is included in the value of other services billed on the same day.' This is clearly erroneous since a device code is never included in a professional service procedure."

Amount in Dispute: $7,809.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed herewith is documentation to support the position taken by Respondent, city of Denton."

Response Submitted by: Harris & Harris, 5300 Bee Cave Road, Building 3, Suite 200, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2004	Professional Medical Services	$7,809.51	$0.00

FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.1 defines words and terms related to medical benefits.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.1 sets out general provisions related to use of the fee guidelines.
4. Former 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
5. Texas Labor Code §413.011 sets out provisions regarding reimbursement policies and guidelines.
6. This request for medical fee dispute resolution was received by the Division on January 24, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on February 1, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - N2 – TWCC CODE: N - NOT APPROPRIATE DOCUMENTED
     Invalid or missing CPT code or HCPC code.
   - F1 – TWCC CODE: F - FEE GUIDELINE MAR REDUCTION
     Charge exceeds the schedule maximum allowance per the Medical Fee Guideline.
   - G90 – TWCC CODE: G - UNBUNDLING (INCLUDED IN GLOBAL)
     The value of this services is included in the value of another service billed on the same date.
   - P54 – TWCC CODE: P - RECOUPMENT OF OVERPAYMENT
     Upon final audit, an overpaymnet [sic] to the provider has been identified. Provider should remit this amount to the carrier as soon as possible.
   - S55 – TWCC CODE: S - SUPPLEMENTAL PAYMENT
     Thank you for your inquiry. Upon re-review, additional benefit is recommended as above.

Issues

1. What is the applicable rule for reimbursement of professional medical services?
2. What is the recommended reimbursement for procedure code 62290?
3. What is the recommended reimbursement for procedure code 00630?
4. What is the applicable rule for reimbursement of items and services for which no payment or relative value has been established?
5. Did the requestor support that additional reimbursement is due for procedure codes 64999 and 9970?
6. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to professional medical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202, effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." §134.202(c) further requires that to determine the maximum allowable reimbursements (MARs) for professional services, system participants shall apply the Medicare payment policies with minimal modifications as provided in the rule.
2. Per §134.202(c)(1), the conversion factor to be used for determining reimbursement of procedure code 62290 is the effective conversion factor adopted by the Centers for Medicare and Medicaid Services (CMS) multiplied by 125%. The 2004 Medicare payment amount for procedure code 62290 provided in Denton, Texas is $345.15. This amount multiplied by 125% is $431.44. This amount is recommended.
3. Per the Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 12, §50.L, at the time of the disputed services, Medicare did not recognize separate payment if the same physician provided the medical or surgical procedure and the anesthesia needed for the procedure. Per Medicare policy, the services furnished under procedure code 00630 may only be provided by an anesthesiologist, certified registered nurse anesthetist, or anesthesia assistant. Review of the submitted medical records finds that the disputed service was not rendered by an appropriately credentialed healthcare provider. Reimbursement cannot be recommended.
4. Procedure codes 64999 and 99070 represent products and services for which CMS or the Division had not established a relative value unit and/or a payment amount during the disputed dates of service. Therefore, per §134.202(c)(6), the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments. 28 Texas Administrative Code §133.1(8),

effective July 15, 2000, 25 *Texas Register* 2115, defines fair and reasonable reimbursement as "reimbursement that meets the standards set out in §413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or . . . the determination of a payment amount for medical treatment(s) and/or service(s) for which the [Division] has established no maximum allowable reimbursement amount." 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011." Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Per former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, if the dispute involves health care for which the Division has not established a maximum allowable reimbursement, the requestor is required to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement" in accordance with §133.1 and §134.1. Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement asserts that "The unlisted procedure code 64999 was paid at an alarmingly low rate. There is no basis for such a low reimbursement which averages three times this amount in 99% of the workman's compensation carriers in the state of Texas."
   - The requestor did not submit documentation to support that procedure code 64999 was paid at a low rate.
   - The requestor did not present documentation to support that reimbursement for this service averages three times greater in 99% of the workman's compensation carriers in the state of Texas.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for procedure codes 64999 or 99070.
   - The requestor did not support that payment of the requested amounts would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement for procedure codes 64999 and 99070 is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
6. The total recommended reimbursement for the services in dispute is $431.44. The insurance carrier has previously paid a total of $642.45. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in this dispute.

Authorized Signature

	Grayson Richardson	March 21, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787,

Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.